PRINTED: 01/21/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 2/27/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FENTRESS COUNTY	206 DUNCAN ST N JAMESTOWN, TN 38556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation during the survey, it was determined the facility failed to maintain the corridor door openings. The findings include: Observation on 1/11/10 at 10:45 AM revealed the resident room #207 door lock was damaged and could not latch when closed. NFPA 101, 7.2.1.5.1. Observation on 1/11/10 at 10:45 AM within the 200 hall revealed the door to the employees lounge had a penetration on one edge. NFPA 80,	K 018	**K 018 NFPA 101 Life Safety Code Standard** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** a. Resident room #207 door lock was replaced by plant operations on 1/14/10 to insure latching when closed. b. Door to the employee lounge area was repaired by plant operations on 1/22/09 to seal the penetration on the side of the door. **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** 2. A 100% audit of the facility has been completed by plant operations on 1/15/10 and not other doors were found to have defects in the door or latching mechanisms. Reviewed by Administrator 1/22/10. **What measures will be put in place or what systematic changes you will make to insure that the deficient practice does not recur.** 3. Administrator to in-service maintenance, housekeeping, and CNA staff on communication procedures to notify plant operations of damage to door or problems with latching mechanisms. All in-services to be completed by 02/05/10. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.** 4. The Administrator and plant operations directoe will conduct a walking round weekly to ensure no damage to doors or latching mechanisms. Results of audits and records of maintenance work orders and repairs will be submitted to the monthly QA/QI committee on a quarterly basis for review and recommendations.	2/5/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		1-29-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 01/21/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FENTRESS COUNTY	206 DUNCAN ST N JAMESTOWN, TN 38556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 1 8.3.4.1; 15.2.5.2; 101, 19.3.6.3.6. The findings were verified by the Maintenace Director and acknowledged by the Facility Administrator during the exit interview on 1/11/10.	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation during the survey, it was determined the facility failed to maintain the horizontal exit door openings. The findings include: On 1/11/10 at 1:00 PM observation of the fire doors next to the rehab office revealed the doors did not close to flush within the frame. NFPA 101, 19.2.2.2.6.	K 021	**K 021 Life Safety Code Standard** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. Doors realigned with the frame to insure that when closed, the doors are flush with the frame.. Completed 1/28/10. **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** 2. Plant operations director conducted a building inspection on 1/22/10 all other horizontal exit doors closed flush with the frame. **What measures will be put in place or what systematic changes you will make to insure that the deficient practice does not recur.** 3. Inspections will be performed by the maintenance department weekly for 4 weeks and then during fire drills to monitor the closure of horizontal exit doors. Any concerns identified will be immediately corrected. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.** 4. The maintenance director or designee will report monthly to the QA/QI committee results of building inspection audits to include closure of horizontal exit doors and corrective actions. Action plans will be developed for any issues that arise.	1/28/10

PRINTED: 01/21/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FENTRESS COUNTY	208 DUNCAN ST N JAMESTOWN, TN 38556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021	Continued From page 2 The findings were verified by the Maintenance Director and acknowledged by the facility administrator during the exit interview on 1/11/10.	K 021		
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation during the survey, it was determined the facility failed to maintain the corridor door openings. National Fire Protection Association (NFPA). 101, 8.3.6. The findings include: 1. Observation on 1/11/10 at 10:45 AM revealed there was a penetration around a sprinkler pipe in 300 hall boiler room cinder block wall. 2. Observation on 1/11/10 at 12:00 PM within the mechanical area of the laundry equipment room revealed there was a penetration around the duct at the cinder wall connection 3. Observation at 12:35 PM within the laundry room area revealed, there was a penetration around a 2" diameter sprinkler pipe. NFPA 101, 8.3.6.1. The findings were verified by the Maintenance Director and acknowledged by the facility Administrator during the exit interview on 1/11/10.	K 104	**K 104 Life Safety Code Standard** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** a. Penetration around a sprinkler pipe in 300 hall boiler room cinder block wall has been sealed with fire caulk on 1/14/10 by plant operations staff. b. Penetration around duct at the cinder block wall in the mechanical area of the laundry equipment room has been sealed with fire caulk on 1/14/10 by plant operations staff.. c. Penetration around a 2" diameter sprinkler pipe in the laundry room area has been sealed with fire caulk on 1/14/10 by the plant operations staff.. **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** 2. Plant operation director conducted a building inspection on 1/14/10 and no other penetrations were found in other mechanical areas or laundry area in the facility. **What measures will be put in place or what systematic changes you will make to insure that the deficient practice does not recur.** 3. As part of weekly building inspection, maintenance will inspect smoke partitions for evidence of unsealed penetrations. Any concerns identified will be immediately communicated to the administrator and immediately repaired. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.** 4. Results of weekly inspections and penetration repairs will be reported to Administrator and QI/QA Committee for review and recommendations.	1/14/10
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

PRINTED: 01/21/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FENTRESS COUNTY	200 DUNCAN ST N JAMESTOWN, TN 38556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144 SS=F	Continued From page 3 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation during the survey, it was determined the facility failed to maintain the emergency generators. The findings include: During record review on 1/11/10 at 2:00 PM discussion with the Maintenance Director revealed the timer clock on the emergency generator was not working. NFPA 110, The finding was verified by the Maintenance Director and acknowledged by the Facility Administrator during the exit interview on 1/11/10.	K 144	**K 144 Life Safety Code** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. Replacement timer ordered when generator serviced by contract company on 12/18/09. Timer unit replaced on 01/27/10 by contract company. **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** 2. If power was lost to facility, then timer had to be reset manually to monitor generator run time. Timer was monitored by maintenance staff during scheduled run time under load for 30 minutes on 12/4/09 and 12/25/09. Generator and timer operated properly. Generator run under load for 30 minutes on 1/1/10, 1/8/10, 1/15/10, 1/22/10, and 1/29/10. No problems noted with timer or generator. **What measures will be put in place or what systematic changes you will make to insure that the deficient practice does not recur.** 3. Plant operations staff conducts weekly generator checks to ensure operational status. Any failure in the emergency generator system or components is to be reported immediately to contract generator maintenance company and to the Administrator, who will monitor response time of company.	1/27/10
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation during the survey, it was determined the facility failed to maintain the electrical system. National Fire Protection	K 147	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.** 4. Failures in generator system will be reported to administrator and QA/QI committee on monthly basis for review and recommendations..	

PRINTED: 01/21/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FENTRESS COUNTY	206 DUNCAN ST N JAMESTOWN, TN 38556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 4 Association (NFPA). 70, 110-13(a). The findings include: Observation on 1/11/10 at 10:45 AM within the 400 hall shower room revealed there was a hanging power strip. The findings were verified by the Maintenance Director and acknowledged by the facility Administrator during the exit interview on 1/11/10.	K 147	**K 147 NFPA 101 Life Safety Code Standard** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. The hanging power strip located on the 400 hall has been secured to the wall on 1/11/10. **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** 1. All other rooms and areas in the facility were inspected on 1/14/10 and no other hanging power strips were found. **What measures will be put in place or what systematic changes you will make to insure that the deficient practice does not recur.** 1. Power strip placement will be monitored daily through department director rounds of the facility. Any issues noted will be placed on maintenance work orders located at each nursing station and plant operations staff will check daily. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.** 1. Any problems with proper strip installation will be reported to the maintenance staff for repair. The results of these rounds and repairs will be reported quarterly to QI/QA committee and appropriate actions plans developed.	1/14/10